MADIGAN ARMY MEDICAL CENTER
REFRACTIVE SURGERY CENTER PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Date: _____ Name (Last, First, MI): _____

DOD ID: _____ FMP/L FOUR: _____ DOB: _____ Age:_____ M F

Rank: _____ Mailing Address: _____

Telephone Number (s): Work: _____ Cell: _____ Home: _____

Branch of Service (circle one): USA USAF USMC USN USCG

Email (.mil) : _____

Unit of Assignment (CO/BN/BDE): _____

Are you BEING deployed to Iraq, Afghanistan or any other location? No Yes Date: _____

ETS Date: _____ PCS Date: _____ TDY/Leave Dates: _____

Have you been previously been screened at Madigan for refractive surgery? Yes No

I, (print name) _____, am a full- time active duty Soldier/Airman assigned to an active duty tenant unit at Joint Base Lewis-McChord. I am NOT on active duty orders as a mobilized Reserve or National Guard Soldier. I am aware that I must have at least 18 months time-in-service left on my Active Duty contract at the time of surgery to be scheduled for surgery (Army only).

Patient Signature: _____

MEDICAL INFORMATION

Are you allergic to any medications? ↑Yes ↑No

If yes, please list medications by name: _____

Have you had any immunizations in the last 12 months? ↑Yes ↑No

If yes, please list them: _____

Please circle and list all medications you are currently taking (include over-the-counter medications and nutritional supplements):

Doxycycline/ tetracycline's Allergy medications Diabetic medications Thyroid medications

Accutane Cordarone Hormone Replacement Therapy Imitrex Coumadin

Any others, please specify: _____

Please describe:

Past surgical history: _____

Major illnesses: _____

Do you smoke? Yes, currently No, never ↑No, I quit (date): _____

*******FEMALE PATIENTS ONLY*******

Are you currently, or have you had/been in the last 6 months:

□ Pregnant □ Nursing □ Miscarriage □ Neither pregnant, nursing, or miscarried in the last 6 months

Patient Signature: _____ **Date:** _____

Name (Last, First MI): _____ DOB: _____

FAMILY HISTORY

Do you have a family history of (please circle below):

Glaucoma	Diabetes	Macular Degeneration	Crossed or Lazy Eye
Cancer	Corneal Disease	High Blood Pressure	Retinitis Pigmentosa
Cataracts	Adopted	Other: _____	None of the above

Have you ever been diagnosed and/or treated for:

	Yes	No
Diabetes (year diagnosed_____)	☐	☐
Heart Disease	☐	☐
Cancer (type _____)	☐	☐
Keloid Scarring	☐	☐
Herpes/Shingles/Cold Sores	☐	☐
High Blood Pressure (Hypertension)	☐	☐
High Cholesterol	☐	☐
Arthritis	☐	☐
Lupus	☐	☐
Thyroid (circle below)	☐	☐
Low High Graves		
Headache (circle below)	☐	☐
Migraine Tension Sinus		
Skin Ailments (circle below)	☐	☐
Eczema Psoriasis Rosacea		
Other autoimmune disease not listed	☐	☐
Please specify _____		
Environmental Allergies	☐	☐

Any medical problem not specified above?

Please specify _____

Have you ever had:

	Yes	No
Dry Eye	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Retinal Detachment	☐	☐
Eye Injury:	☐	☐
please specify _____		
Macular Degeneration	☐	☐
Iritis/Uveitis	☐	☐
Crossed Eye(s)	☐	☐
Lazy Eye/Amblyopia	☐	☐
Eye Surgery (circle one): LASIK PRK N/A		
Date/Location: _____		
Eye Surgery (Other):	☐	☐
Please specify _____		
Eye Infection:	☐	☐
please specify _____		
Any eye problem(s) not specified above?		
please specify _____		

GLASSES/CONTACT HISTORY

Do you now, or have you ever, worn glasses? Yes No If yes, how long? _____

Do you now, or have you ever worn contact lenses? Yes No If yes, see below:

↑Hard contact lenses: _____ years ↑Soft contact lenses: _____ years

Date you last wore your contact lenses: _____

Any problems while wearing contact lenses? (ie: dry eye, lens intolerance, infections, red eyes, etc)

Yes ↑No If yes, please specify: _____

Knowing that there can be **no guarantee** that glasses or contact lenses will no longer be necessary, what do you hope to achieve from having laser eye surgery? _____

_____

_____

(Refractive)

SURGEON SIGNATURE: _____ **DATE:** _____